Center for Health, Learning & Achievement

310 Waymont Ct. Suite 104 Lake Mary, FL 32746
Office - 407-718-4430
Fax 321-363-1041

AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED INFORMATION

I authorize ____

Name of Associate

____

Street Address City State Zip Code

____________________ ____________________

Phone Number Fax Number

To release to and/or receive from:

____

The following records and information:

_Psychiatric Evaluation
_History
_Therapy/Counseling
_Reports
_Medical
_Evaluations
_Employment
_School/Guidance ____________________
_Other: _______________

The purpose of releasing/exchanging such information is:

_To contribute to evaluation/assessment.
_To assist with planning treatment.
_Other: ____

I understand that this information will be used solely for professional purposes, will remain confidential, and may not be disclosed to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance thereon. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original.

Client Name: ____

Birth Date: _____________

____ __________________

Client Signature (or Parent/Guardian/Representative) Date